STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

IN RE: REVIEW OF AGGREGATE MEASURABLE COST SAVINGS DETERMINED BY DIRIGO HEALTH FOR THE FOURTH ASSESSMENT YEAR	)))))
DOCKET NO. INS-08-900	)

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STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
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IN RE: REVIEW OF AGGREGATE MEASURABLE COST SAVINGS DETERMINED BY DIRIGO HEALTH FOR THE FOURTH ASSESSMENT YEAR	)	BRIEF OF THE MAINE AUTOMOBILE DEALERS ASSOCIATION INSURANCE TRUST
DOCKET NO. INS-08-900	)	

NOW COMES the Intervenor, Maine Automobile Dealers Association Insurance Trust (the "Trust"), by and through its undersigned counsel, and, pursuant to the Superintendent's Notice of Pending Proceeding and Hearing and Order Setting Actual Hearing Date, Ruling on Interventions, and Establishing Procedures, submits the following brief.

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INTRODUCTION

Like a book in the *Harry Potter* series, the Decision filed by the Dirigo Health Agency Board of Directors ("DHA Board") setting forth its determination of aggregate measurable cost savings ("AMCS") for the Fourth Assessment Year requires the reader to engage in the willing suspension of disbelief. In the face of uncontroverted evidence in the record that enrollment in DirigoChoice has declined approximately 15 percent (from 14,185 to 12,050) since last year, the DHA Board would have the Superintendent and the people of Maine believe that the AMCS this year as a result of the operation of Dirigo Health totals $149.6 million. That amount, however, is $116.8 million greater than the amount approved just last year and $38.8 million greater than the total amount of AMCS approved for the past three years *combined*. The DHA Board has now strained credulity well beyond the breaking point.

ARGUMENT

To avoid undue repetition, the Trust adopts the arguments set forth in the brief filed by the Maine State Chamber of Commerce ("Chamber"), and, to the extent to which they do not advance a "rough justice" alternative AMCS figure, those set forth in the briefs of Anthem Health Plans of Maine, d/b/a Anthem Blue Cross and Blue Shield ("Anthem") and the Maine Association of Health Plans ("MAHP").

I. The Claimed CMAD Savings Are Based Upon An Unsupportable Methodology.

In its Decision, the DHA Board found $119.4 million in CMAD savings or approximately 81 percent of the $147.9 million in CMAD savings proposed by the DHA and its consultant, Schramm Raleigh Health Strategy ("srHS"). (Decision at 5, 6, 8, 10; Administrative Record "AR" Binder 4 Tab 64 at p. 22; AR Binder 4 Tab 82 at pp. 4, 17).

A. The CMAD Methodology Ignores The CMAD Formula Set Forth In The Statute.

As it has in past years, srHS claims that savings attributed to CMAD are appropriately included in the Board's AMCS determination because the statute specifically includes a voluntary CMAD target. (AR Binder 4 Tab 64 at p. 26; AR Binder 4 Tab 82 at pp. 21, 99-100, 108-109, 112-13). srHS, however, is quite selective in terms of the statutory language on which it chooses to rely.

The provision on which srHS relies as providing the statutory basis for the inclusion of CMAD savings in AMCS is P.L. 2005, ch. 394, § 4(B), which sets forth a voluntary cost control target for hospitals determined in reference to increases in their CMAD. In setting the voluntary target, the Legislature also provided a detailed formula for calculating CMAD:

> For purposes of this paragraph, the measure of a hospital's expense per casemix-adjusted inpatient and volume-adjusted outpatient discharge is calculated by:
>
> (1) Calculating the hospital's total hospital expenses;
>
> (2) Subtracting from the hospital's total hospital-only expenses the amount of the hospital's bad debt;
>
> (3) Subtracting from the amount reached in subparagraph (2) the hospital taxes paid to the State during the hospital's fiscal year; and
>
> (4) Dividing the amount reached in subparagraph (3) by the product of:
>
> (a) The number of inpatient discharges, adjusted by the all payer case mix index for the hospital; and
>
> (b) The ratio of total gross patient service revenue to gross inpatient service revenue.
>
> For the purposes of this paragraph, a hospital's total hospital-only expenses include any item that is listed on the hospital's Medicare cost report as a subprovider, such as psychiatric unit or rehabilitation unit, and does not include nonhospital cost centers shown on the hospital's Medicare cost report, such as home health agencies, nursing facilities, swing beds, skilled nursing facilities and hospital-owned physician practices. For purposes of this paragraph, a hospital's bad debt is as defined and reported in the hospital's Medicare cost report.

(AR Binder 5 Tab 95 at A). Thus, not only did the Legislature set a voluntary cost control target measured by increases in CMAD, it specifically set forth the formula pursuant to which CMAD was to be calculated for purposes of determining whether the target was met.

As it is wont to do when it feels constrained by the rules of the game, however, srHS summarily cast aside the statutory CMAD formula and instead made up its own.[1] Indeed, Steven Schramm of srHS admitted that the CMAD methodology proposed by srHS is *not* consistent with the CMAD formula set forth by the Legislature in Chapter 394, Section 4(B). (AR Binder 2 Tab 60 at pp. 110-12). In other words, srHS is more than happy to utilize Chapter 394, Section 4(B) as the statutory basis for including CMAD in AMCS in the first instance, but prefers to use its own method of calculating CMAD when it comes time to generate a CMAD savings figure. srHS cannot simply choose cafeteria style the portions of the Dirigo Health Act to its liking.

CMAD as a concept in the Dirigo Health Act exists only in the context of the formula the Legislature used to define it. Allowing srHS to include CMAD in AMCS because it is mentioned in the Dirigo Health Act while simultaneously ignoring the formula for calculating it contained within the very same subsection effectively renders the Legislature's 192-word formula superfluous, in contravention of the canon of statutory construction that wherever possible meaning must be given to every word and phrase in a statute. See Handyman Equip. Rental Co., Inc. v. City of Portland, 1999 ME 20, ¶ 9, 724 A.2d 605, 607-608. A CMAD methodology, such as the one at issue here, that is inconsistent with the CMAD formula the Legislature expressly set forth in Chapter 394, Section 4(B) is unreasonable as a matter of law,

[1] The briefs of the other intervenors outline in detail many of the srHS manipulations of data and, having been incorporated by reference, do not require extensive elaboration here. Suffice it to say, however, that relying on anomalous pre-Dirigo CMAD growth rates, employing methodologies that produce Dirigo savings in a majority of states, characterizing a nationwide timeline as related to the Dirigo Act, not controlling effectively for non-Dirigo factors, and accepting as statistically significant assumptions and conclusions which would render the srHS analysis unworthy even of peer reviewed publication render the Board's decision unsupportable. Yet this is proposed as the underpinnings for a broad based tax?

and, therefore, cannot provide the basis for *any* CMAD savings included in an AMCS determination.

B. The Variables Driving The CMAD Savings Are Not Statistically Significant.

srHS developed CMAD methodology whereby it compared the observed post-Dirigo rate of growth of CMAD in Maine with the projected rates of growth in CMAD in the U.S. as a whole (the "U.S. Model"), as well as in a cluster of several states purportedly similar to Maine (the "Cluster Model"). srHS then weighted the U.S. Model 75 percent and the Cluster Model 25 percent to arrive at a proposed CMAD savings amount of $147.9 million. (Decision at 5-7; AR Binder 2 Tab 60 at pp. 25-29; AR Binder 4 Tab 64 at pp. 52-54).

After rejecting the Cluster Model due to the dissimilarity of the cluster states to Maine, and rejecting as arbitrary srHS's 75/25 weighting of the models, the Board relied exclusively on srHS's U.S. Model to arrive at CMAD savings of $119.4 million. (Decision at 8). Although the Board properly rejected the Cluster Model and srHS's weighting approach, it erred in not likewise rejecting the U.S. Model.

As pointed out by Dr. Allen Dobson and Vincent Maffei (AR Binder 1 Tab 35 at pp. 14, 16, 17, 21, 23-27; AR Binder 5 Tab 106 at pp.5-6, 13-18; AR Binder 3 Tab 61 at pp. 33-35, 37, 67-68, 122-23), admitted by Mr. Schramm and Dr. Kenneth Thorpe (AR Binder 2 Tab 60 at pp. 82-83, 198, 228, 237-38), and recognized by the Board itself (Decision at 6, 7), *none* of the variables driving the U.S. Model is statistically significant. In other words, the srHS CMAD methodology does not adequately demonstrate that the proposed CMAD savings are the result of Dirigo as opposed to random chance. While Mr. Schramm and Dr. Thorpe attempt to downplay

the lack of statistical significance, the fact remains that their CMAD methodology is based *entirely* on statistical analysis.

To obtain the imprimatur of statistical validity, srHS's CMAD methodology must adhere to the basic tenets of statistical analysis, including statistical significance. When the Superintendent made it clear in his Decision last year that CMAD savings should be calculated through the use of a multivariate regression analysis, it is safe to assume that what he had in mind was a methodology adhering to the statistical principles that make regression analysis a valid analytical tool; the DHA analysis adopted by the Board does not even meet a "close enough for horseshoes and hand grenades" standard. Because it is undisputed that the CMAD methodology fails the test of statistical significance it must be rejected as a basis for determining AMCS.

II. srHS's Bad Debt/Charity Care Methodology Does Not Pass The Straight Face Test.

For the third straight year, srHS proffered a new methodology for calculating Bad Debt and Charity Care ("BD/CC") savings. This year, the srHS methodology measured BD/CC savings by way of a multivariate analysis that purported to compare the pre- and post-Dirigo percentages of uninsured in Maine and arrived at a total figure of $35.7 million. (Decision at 5, 8; AR Binder 4 Tab 64 at pp. 16-18). The Board approved $23.6 million of the claimed savings. (Decision at 9, 11). The Board's paring of srHS's proposed BD/CC savings figure, however, only turns down the volume of the laughter a bit, it does not eliminate it.

Although enrollment in DirigoChoice has fallen from 14,185 in 2007 to 12,050 in June 2008, a decline of approximately 15 percent (AR Binder 3 Tab 61 at p. 322; AR Binder 5 Tab 97 at Internal Exh. 2 p. 11; AR Binder 5 Tab 97 at Internal Exh. 6 p. 2), the BD/CC savings found by the Board are $17.3 million higher than the BD/CC savings approved last year. (AR Binder 3

Tab 61 at p. 291). Quite simply, it defies logic to suggest that a program with *declining* enrollment has generated a nearly three-fold *increase* in BD/CC savings year-over-year.

In years past, the BD/CC methodology sought to quantify the reduction in BD/CC attributable to enrollment in DirigoChoice by the previously un- or under-insured and increased MaineCare enrollment due to eligibility expansions. This year, the BD/CC analysis seeks to quantify the reduction in BD/CC attributable, so the story goes, to the "fact" that the percentage of uninsured Mainers is estimated to be lower now than it would be if Dirigo never existed. In other words, the BD/CC methodology claims in the name of Dirigo purported savings spawned as a result, for example, of a previously uninsured's enrollment in an Aetna or Anthem plan. In reality, this is nothing more than a slightly warmed over version of the so-called "woodwork effect" whereby the increased public consciousness spawned by Dirigo supposedly causes people to "come out of the woodwork" and obtain health insurance coverage; a methodology rejected by the Superintendent in the First and Second Assessment Years. See Decisions in INS-05-700 and INS-06-900.

III. Aetna's Refunds To Its Policyholders Are Not "Savings" To The Healthcare System.

srHS proposed, and the Board approved, $6.6 million in savings attributable to the so-called "Medical Loss Ratio." (Decision at 5, 9, 10, 11). Those "savings" consist of $6.6 million paid to certain policyholders by Aetna because Aetna failed to meet the 78 percent medical loss ratio set forth in 24-A M.R.S.A. § 2808-B(2-C)(C). Aetna's payments are exactly what the statute says they are—refunds of "excess premiums." No healthcare costs were reduced or avoided, Aetna simply returned premiums it over-collected. Only on Planet Dirigo does the healthcare system at large save money when an insurance company returns to a policyholder that policyholder's own money.

Consider the following:

> Policyholder X receives a bill from Insurance Company Y in the amount of $1,000 for his family's health insurance premium. Distracted, X mistakenly writes a check for $10,000 and sends it to Y. Upon receipt, Y notices the error and immediately sends a refund check to X in the amount of $9,000.

The Trust submits that not one person involved in this proceeding would say that Y's refund check to X represents a "savings" to the healthcare system, yet there is no meaningful distinction between the hypothetical and Aetna's refunds to its policyholders.

At some point common sense has to prevail.

IV. The Board Improperly Failed To Consider Recoverability.

"Recoverability" is the concept advanced by the Intervenors that cost savings cannot legitimately be included in AMCS unless they are actually recoverable by payors. Once again, as Mr. Schramm acknowledged, the srHS methodology that was largely adopted by the Board did not take into consideration whether any of the cost savings proposed for inclusion in AMCS were actually recoverable. (AR Binder 2 Tab 60 at pp. 37, 145, 271-72; AR Binder 4 Tab 82 at pp. 6-7). Indeed, astonishingly the DHA argues that recoverability is not properly considered in the AMCS process at all. (AR Binder 2 Tab 50 at p. 3). In fact, the Board's decision does not consider recoverability.

However, just last year, both the Superintendent and the Board reduced savings proposed by the DHA and srHS precisely because they were not recoverable. See Year 3 Board Decision @9; Year 3 Superintendent's Decision @ 7, 11. Despite the fact that the Superintendent and the Board have expressly found recoverability to be relevant in determining AMCS, srHS failed to address it in its methodology and the Board ignored the evidence on the issue presented by the Intervenors.

The dominoes line up thusly - the Board has ignored the statutory formula for calculating CMAD, it has ignored the lack of statistical significance of the key variables driving the srHS CMAD methodology, its BD/CC findings are a tautology of the woodwork effect, and it has ignored the issue of recoverability altogether. It is clear, therefore, that the Board was going to approve a huge AMCS figure come Hell or high water.

CONCLUSION

For all of the foregoing reasons, the Superintendent should disapprove the Board's filing in its entirety.

Dated: August 26, 2008

Respectfully submitted,

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